STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 01 B. WING	04/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/30/12 Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, University Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. There are no smoke detectors in the resident rooms at this time. The facility has a capacity of 75 and had a census of 55 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/04/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 10 resident room doors protecting corridor openings on the Cottage. This deficient practice could affect 16 residents in the Cottage. Findings include: Based on observation with the Maintenance Supervisor on 04/30/12 at 2:40 p.m., the corridor door to resident room 207 could not be closed because it was obstructed by a resident bed. This was acknowledged by the Maintenance Supervisor.	K0018	K 018: Resident Room Doors Not Closing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The beds in Room 207 were rearranged to allow the door to close properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	05/30/2012

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	3.1-19(b)		· All residents have the potential to be affected by the deficient practice. · Memory Care Facilitator/Designee will monitor all residents' rooms to ensure the doors close properly. · Any rooms found to have a corridor door that will not close properly will be corrected immediately. · Memory Care Facilitator/Designee will document this monitoring on the Auguste's Cottage Room Roster. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Memory Care Facilitator/Designee will monitor all residents' rooms to ensure the doors close properly. · Any rooms found to have a corridor door that will not close properly will be corrected immediately · All rooms will be monitored on a daily basis for 4 weeks, then weekly for 3 months, then monthly thereafter for a minimum	

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			of six months. · Memory Care Facilitator/Designee will document this monitoring on the Auguste's Cottage Room Roster. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · Memory Care Facilitator/Designee will monitor all residents' rooms to ensure the doors close properly. · All rooms will be monitored on a daily basis for 4 weeks, then weekly for 3 months, then monthly thereafter for a minimum of six months. · Memory Care Facilitator/Designee will document this monitoring on the Auguste's Cottage Room Roster. · The Auguste's Cottage Room Roster Monitoring tool will be reviewed at the monthly CQI for a minimum of six months and the plan will be adjusted as necessary.	

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			By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridors doors 2 of 2 hazardous areas such as water heater rooms and rooms with combustible storage measuring over 50 square feet in size were provided with a self closing device. This deficient practice could affect any resident near the 300 hall clean utility room and any staff in the service hall. Findings include: Based on observations with the Maintenance Supervisor on 04/30/12 from 1:35 p.m. to 2:50 p.m., the corridor door to the the service hall water heater room and door to the 300 hall clean utility room measuring fifty four square	K0029	K 029: Self Closing Doors What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The door to the service hall water heater room and the door to the 300 Hall clean utility room have had self closing devices installed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	05/30/2012

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	feet in size with combustible storage, such as bedding, each lacked a self closing device. This was confirmed by the Maintenance Supervisor at the time of the observations. 3.1-19(b)		· All residents have the potential to be affected by the deficient practice. · The doors to the service hall water heater room and to the 300 Hall clean utility room have had self closing devices installed. · All other corridor doors in the facility for hazardous areas such as mechanical and storage rooms have been checked for self closures. · Those doors found to be in need of self closures have had them installed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Maintenance Director will monitor all rooms in the facility on a monthly basis to ensure the door does not require a self closure. · The Maintenance Director will be responsible to ensure all doors in the facility that need self closures have them installed · The Maintenance Director will ensure that any new doors installed in hazardous areas or	

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			storage rooms will have self closures. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director will monitor all rooms in the facility on a monthly basis to ensure the door does not require a self closure. · These inspections will be documented on Maintenance Director's Preventative Maintenance Monthly Checklist. · The Executive Director will audit the Preventative Maintenance Manual at the end of the month to ensure all weekly and monthly audits have been completed. The Executive Director will sign the pages of the appropriate Preventative Maintenance Checklists as documentation that the manual has been reviewed. · Any discrepancies in the plan will be reviewed at the monthly CQI meeting for a minimum of six months. The plan will be adjusted as necessary.	

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			By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 6 of 8 exit doors were accessible. Health care occupancies are permitted delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect any number of occupants. Findings include: Based on observations with the Maintenance Supervisor on 04/30/12 from 1:15 p.m. to 2:30 p.m., the exit doors on the 100 hall, in the 300 lounge, on the	K0038	K 038 Exit Access What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · All exit doors in the facility, except those located in the Auguste's Cottage Alzheimer's Unit, have the appropriate signage posted regarding pushing the door for 15 seconds to open. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · All exit doors in the facility, except those located in the Auguste's Cottage Alzheimer's Unit, have the appropriate	05/30/2012

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	300 hall, in the main dining room, in the vending machine area and at the main entrance were equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked signage regarding pushing the door to open. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-15(b)		signage posted regarding pushing the door for 15 seconds to open. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Maintenance Director/Designee will monitor all exit doors, except those in Auguste's Cottage Alzheimer's Unit, to ensure the posted signs are in place. · Any doors found to be without the appropriate signage will have the signs replaced immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will monitor all exit doors, except those in Auguste's Cottage Alzheimer's Unit, to ensure the posted signs are in place. · This exit door monitoring will	

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			be documented on the CQI Exit Sign Monitoring Tool. · This monitoring will be done on a weekly basis for 4 weeks, then monthly thereafter for a minimum of six months. · The CQI Exit Sign Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Fire Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any of the 24 residents on the 100 hall. Findings include: Based on observation with the Maintenance Supervisor on 04/30/12 at 1:05 p.m., a raised area of the concrete floor prevented the east side fire door on the 100 hall from closing completely and latching into the	K0044	K 044 Horizontal Exits What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The fire doors in the 100 Hall have been repaired and now close properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · The fire doors in the 100 Hall have been repaired and now close properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Maintenance Director/Designee will monitor all fire doors on a weekly basis to ensure the doors close properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will monitor all fire doors on a weekly basis to ensure the doors close properly. · The monitoring of the fire doors will be documented on the Preventative Maintenance Weekly Checklist. . · The Executive	05/30/2012

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	door frame. There was a fourteen inch gap between the door and the door frame. Based on an interview with the Maintenance Supervisor at the time of observation, these doors were confirmed to be fire doors. 3.1-19(b)		Director/Designee will monitor the Preventative Maintenance Checklist on a weekly basis for 4 weeks, then monthly thereafter for a minimum of six months. This monitoring will be documented on the CQI Preventative Maintenance Weekly/Monthly Checklist Monitoring Tool. · The CQI Preventative Maintenance Weekly/Monthly Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the use of all fire extinguishers in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Supervisor on 04/30/12 at 12:55 p.m., the "Fire Action Plan" did not address the	K0048	K 048 Fire Extinguishers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The facility's Emergency Fire Plan has been updated to include the types of fire extinguishers throughout the facility; including the kitchen K class in relationship with the use of the kitchen hood extinguishing system. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · The facility's Emergency Fire Plan has been updated to	05/30/2012

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	types of fire extinguishers throughout the facility including the kitchen K class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review. 3.1-19(b)		include the types of fire extinguishers throughout the facility; including the kitchen K class in relationship with the use of the kitchen hood extinguishing system. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The facility's CQI Committee was reviewed and updated the American Senior Communities Disaster Manual at their meeting on 05.17.12. · The American Senior Communities Disaster Manual includes the required information on the types and uses for the fire extinguishers located throughout the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will be responsible to monitor all fire	

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			extinguishers throughout the facility to ensure the correct fire extinguishers are in use in the proper areas of the facility. · The Maintenance Director/Designee will be responsible to monitor all fire extinguishers throughout the facility to ensure they are inspected by our service provider as required. · The Maintenance Director/Designee will document this monitoring on the Preventative Maintenance Weekly/Monthly Checklist on a monthly basis for a minimum of 12 months. · The Executive Director will review the Preventative Maintenance Checklist on a monthly basis to ensure all required inspections have occurred. The Executive Director will document these reviews by signing the Preventative Maintenance Checklists. · The CQI Preventative Maintenance Weekly/Monthly Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed:	

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			· Systemic changes will be completed by 05/30/12.	

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K0062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Supervisor during the review of the P.I.P.E sprinkler inspection on 04/30/12 at 12:48 p.m., there was no documentation to show an internal pipe inspection for the dry sprinkler piping system had been completed. This was confirmed by the Maintenance Supervisor at the time of record review. Based on an interview with the Maintenance Supervisor at the	K0062	K 062 Automatic Sprinkler Systems What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The dry sprinkler piping system was inspected on 06/29/07. A reinspection has been scheduled for June. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · The dry sprinkler piping system was inspected on 06/29/07.	05/30/2012

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	time of record review, the dry sprinkler piping system is in the attic and the electrical room. 3.1-19(b)		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. · All required inspections will be kept by the Maintenance Director in an inspections binder. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. · All required inspections will be kept by the Maintenance Director in an Inspections Binder. · The Executive Director/Designee will monitor the	

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			Inspections Binder on a monthly basis to ensure the required inspections have been completed. · The Inspection Binder will be monitored for a minimum of 12 months and documented on the CQI Inspections Monitoring Tool located in front of the Inspection Binder · The CQI Inspections Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect any resident in the dining room and kitchen staff in the event of an emergency. Findings include: Based on record review with Maintenance Supervisor on 04/30/12 at 12:41 p.m., the last kitchen hood inspection was completed by Elwood Fire Equipment on 07/08/11. Based on an interview with the Maintenance Supervisor at the time of record review, the facility was purchased by American Seniors at the beginning of the year and the kitchen hood	K0069	K 069 Dietary Hood Inspections What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · The dietary hood extinguishing system was inspected on 05/04/12. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · The dietary hood extinguishing system was inspected on 05/04/12. What measures will be put into place or what systemic changes	05/30/2012

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	inspection may have been forgotten. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 hood extinguishing systems was provided with baffle filters. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 3.1 states mesh filter shall not be used. This deficient practice could affect any resident in the dining room and kitchen staff in the event of an emergency. Finding include: Based on observation of the kitchen hood system with the Maintenance Supervisor on 04/30/12 at 2:55 p.m., mesh filters were in use. Based on an interview with the Maintenance Supervisor at the time of interview, the facility was aware there were mesh filters in the hood system. 3.1-19(b)		will be made to ensure that the deficient practice does not recur: · The Maintenance Director will be responsible to ensure all inspections are completed as required. · All required inspections will be kept by the Maintenance Director in an inspections binder. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. · All required inspections will be kept by the Maintenance Director in an inspections binder. · The Executive Director/Designee will monitor the inspections binder on a monthly basis to ensure the required inspections have been completed. · The Inspection Binder will be	

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			monitored for a minimum of 12 months and documented on the CQI Inspections Monitoring Tool located in front of the Inspection Binder · The CQI Inspections Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 05/30/12.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of	K0144	K 144 Generator Inspections What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · 1) A new emergency generator, remote annunciator with audible and visual alarms and battery charger is being installed at the facility. The completion date for this project is 07/20/12. We are requesting a temporary waiver. · 2) Generator load tests will be performed on a monthly basis as required. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · All residents have the potential to be affected by the deficient practice. · 1) A new emergency generator, remote annunciator with audible and visual alarms and battery charger is being installed at the facility. The completion date for this project is 07/15/12. · 2) Generator load tests will	07/20/2012

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	an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on an observation with Maintenance Supervisor on 04/30/12 at 1:10 p.m., the emergency generator remote annunciator panel only had alarm indicator lights for high engine temperature, low oil and overcrank. This was		be performed on a monthly basis as required. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · 1) A new emergency generator, remote annunciator with audible and visual alarms and battery charger is being installed at the facility. The completion date for this project is 07/20/12. We are requesting a temporary waiver. · To date the supplier has poured the cement slab and installed the annunciator panel. The panel is being installed across from the nurses' station. This location provides direct monitoring and accessibly capabilities by the licensed staff. · 2) The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. · The Executive Director inserviced the Maintenance Director on the emergency generator required load tests, documenting the load tests and maintaining those load tests for record review. All required inspections will be kept by the Maintenance Director in an inspections binder. How the corrective action(s) will be monitored to ensure the	

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	acknowledged by the Maintenance Supervisor at the time of observation. 3-1.19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having		deficient practice will not recur; i.e. what quality assurance program will be put into place: · The Maintenance Director/Designee will be responsible to ensure all inspections are completed as required. · All required inspections will be kept by the Maintenance Director in an Inspections Binder. · The Executive Director/Designee will monitor the Inspections Binder on a monthly basis to ensure the required inspections have been completed. · The Inspection Binder will be monitored for a minimum of 12 months and documented on the CQI Inspections Monitoring Tool located in front of the Inspection Binder · The CQI Inspections Monitoring Tool will be reviewed for compliance at the monthly CQI meeting for a minimum of 6 months. By what date the systemic changes will be completed: · Systemic changes will be completed by 07/20/12.	

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	jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review of the generator "Weekly Exercise/Monthly Load Test Log" with the Maintenance Supervisor on 04/30/12 at 12:05 p.m., there was no documentation of a generator load test for the months of October through December 2011. This was acknowledged by the Maintenance Supervisor at the time of record review. 3.1-19(b)			